| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 15G393 | A. BUILDING 00<br>B. WING | 09/08/2011 |

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| DEVELOPMENTAL SERVICES INC | 113 JENNINGS ST<br>NORTH VERNON, IN47265 |

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| W0000 | This visit was for the post certification revisit (PCR) to the annual fundamental recertification and state licensure survey completed on 7/15/11. This PCR survey resulted in an Immediate Jeopardy.<br><br>Dates of Survey: September 1, 2, 6, 7, and 8, 2011.<br><br>Surveyor: Dotty Walton, Medical Surveyor III<br><br>Facility Number: 000907<br>AIM Number: 100244410<br>Provider Number: 15G393<br><br>The following deficiencies reflect findings in accordance with 431 IAC 1.1.<br>Quality Review completed 9/9/11 by Ruth Shackelford, Medical Surveyor III. | W0000 | | |
| W0102 | The facility must ensure that specific governing body and management requirements are met.<br>Based on observation, record review and interview for 4 of 4 sampled clients (#1, #2, #3, and #4), and 4 additional clients (#5, #6, #7, and #8), the facility failed to meet the Condition of Participation: | W0102 | Senior managementi has reviewed agency policies and procedures regarding prohibiting clienti abuse and neglecti. Iti was detiermined tihati agency policies are clearly deftned in regards tio prohibiting abuse and | 09/22/2011 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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| | Governing Body.<br><br>Findings include:<br><br>Please refer to W104 for 4 of 4 sampled clients (#1, #2, #3, and #4), and 4 additional clients (#5, #6, #7, and #8), for the Governing Body's failure to exercise general operating direction over the facility by failing to implement policies and procedures which prohibited client neglect and abuse.<br><br>Please refer to W122 Condition of Participation: Client Protections for 4 of 4 sampled clients (#1, #2, #3, and #4), and 4 additional clients (#5, #6, #7, and #8), for the facility's neglecting to implement policies and procedures which prohibited verbal, emotional and physical abuse of clients. The facility also failed to report, investigate and implement remedies regarding verbal, emotional and physical abuse of clients. This failure resulted in Immediate Jeopardy.<br><br>Please refer to W266 Condition of Participation: Client Behavior & Facility Practices for 4 of 4 sampled clients (#1, #2, #3, and #4), and 4 additional clients (#5, #6, #7, and #8), for the facility's failure to implement, revise and manage client #8's verbal, emotional and physical abuse of clients #1, #2, #3, #4, #5, #6 and | | neglecti. Stiaft have been retirained on tihese policies. A Behavioral Clinician has been obtiained ftor Clienti#8 and a Behavior Supporti Plan has been developed tio coincide witih tihe Plan oft Action tihati was modifted. Clienti#8's guardian has given verbal approval ftor botih plans. HRC approval was obtiained ftor botih plans and all stiaft have been tirained A new psychiatiristi has been contiactied ftor Clienti#8 as well as a counselor. Appointimentis are being scheduled ftor each oft tihese Modiftcations are being made in tihe home tio provide a privatie room ftor Clienti#8. This will in tiurn provide a privatie room ftor Clienti#4 who was Clienti#8's roommatie All clienti's bedroom doors now have door handles tihati lock Each clienti has been provided a key tio her door, in addition stiaft have a key tio each door. Additional stiaft have been added tio each shift tio ensure tihe healtih and saftetiy oft all residentis in tihis home. QIDP Assistianti or SGL Division manager (acting QIDP), will do observations in tihe home ati leasti weekly ftor one montih tio ensure plans are being implementied and policies and procedures are upheld. Random observations will continue after one montih<br>Responsible for QA: Senior Management, SGL Division Manager, QIDP | |

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| | #7.<br><br>1.1-3-1(a) | | | |
| W0104 | The governing body must exercise general policy, budget, and operating direction over the facility.<br>Based on observation, record review and interview for 4 of 4 sampled clients (#1, #2, #3, and #4), and 4 additional clients (#5, #6, #7, and #8), the Governing Body failed to exercise general operating direction over the facility by failing to implement policies and procedures which prohibited client neglect and abuse. | W0104 | Senior managementi has reviewed agency policies and procedures regarding prohibiting clienti abuse and neglecti. Iti was detiermined tihati agency policies are clearly deftned in regards tio prohibiting abuse and neglecti. Stiaft have been retirained on tihese policies. A Behavioral Clinician has been obtiained ftor Clienti#8 and a Behavior Supporti | 09/22/2011 |

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| | Findings include:<br><br>The Governing Body failed to exercise general policy and operating direction over the facility in that the governing body neglected to implement written policies and procedures which prohibited the verbal, emotional and physical abuse of clients #1, #2, #3, #4, #5, #6 and #7 by client #8 which resulted in Immediate Jeopardy.<br><br>Review of agency policies and procedures on 9/06/11 at 1:30 PM and on 9/08/11 at 3:45 PM indicated the 4/12/2006 Standard Operating Procedure for Individual Rights (and) Protection.<br>Purpose:<br>"To establish policies and procedures to ensure the health, safety and rights of individuals served by (the agency) are at the forefront of service delivery.<br>Any event involving the potential or actual risk of harm to a client served, will be documented, reported, investigated and corrective action taken to alleviate the potential for future risk....It is the responsibility of management to exercise prudent judgment in establishing proactive strategies as well as reactive strategies to alleviate future reoccurrences of violations of individual rights and protection." | | Plan has been developed tio coincide witih tihe Plan oft Action tihati was modifted. Clienti#8's guardian has given verbal approval ftor botih plans. HRC approval was obtiained ftor botih plans and all stiaft have been tirained A new psychiatiristi has been contiactied ftor Clien#8 as well as a counselor. Appointimentis are being scheduled ftor each oft tihese Modiftcations are being made in tihe home tio provide a privatie room ftor Clienti#8. This will in tiurn provide a privatie room ftor Clien#4 who was Clienti#8's roommatie All clienti's bedroom doors now have door handles tihati lock Each clienti has been provided a key tio her door, in addition stiaft have a key tio each door. Additional stiaft have been added tio each shift tio ensure tihe healtih and saftetiy oft all residentis in tihis home. QIDP Assistianti or SGL Division manager (acting QIDP), will do observations in tihe home ati leasti weekly ftor one montih tio ensure plans are being implementied and policies and procedures are upheld. Random observations will continue after one montih<br>Responsible for QA: Senior Management, SGL Division Manager, QIDP | |

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| | Please refer to W127 for the facility failure to prevent physical, emotional and verbal abuse of clients.<br><br>1.1-3-1(a) | | | |
| W0122 | The facility must ensure that specific client protections requirements are met.<br>Based on observation, record review and interview for 4 of 4 sampled clients (#1, #2, #3, and #4), and 4 additional clients (#5, #6, #7, and #8), the facility failed to meet the Condition of Participation: Client Protections.<br><br>Findings include:<br><br>Based on observation, record review and interview for 4 of 4 sampled clients (#1, #2, #3, and #4), and 4 additional clients (#5, #6, #7, and #8), the facility failed to ensure the rights of all clients to be free of neglect, verbal, emotional and physical abuse by failing to address client #8's tantrums, property destruction, physical and verbal aggression.<br><br>An Immediate Jeopardy was identified on 9/01/2011 at 5:40 PM that had existed at the facility since 9/01/2011 at 4:10 PM. The Agency Supervised Group Living Division Manager, was notified of the | W0122 | A Behavioral Clinician has been obtiained ftor Clienti#8 and a Behavior Supporti Plan has been developed tio coincide witih tihe Plan oft Action tihati was modifted Clienti #8's guardian has given verbal approval ftor botih plans HRC approval was obtiained ftor botih plans and all stiaft have been tirained A new psychiatiristi has been contiactied ftor Clienti#8 as well as a counselor. Appointimentis are being scheduled ftor each oft tihese Modiftcations are being made in tihe home tio provide a privatie room ftor Clienti#8. This will in tiurn provide a privatie room ftor Clienti#4 who was Clienti#8's roommatie All clienti's bedroom doors now have door handles tihati lock Each clienti has been provided a key tio her door, in addition stiaft have a key tio each door.<br>Responsible ftor QA QIDP/SGL Manager | 09/22/2011 |

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| | Immediate Jeopardy on 9/01/2011 at 5:50 PM. The facility offered a Plan of Action to remove the Immediate Jeopardy on 9/01/2011 at 8:45 PM which included the following:<br><br>"Immediate action taken:...no less than 2 staff members (sic.) be on duty any time (client #8) is present in the home until further notice.<br>Extra staff was arranged for overnight tonight 9/1/11. (Client #8) will be going home 9/2/11 after work and will not return until Monday afternoon 9/5/11. A second staff person has been scheduled for overnight shift starting again on 9/5/11 and will continue until further notice."<br><br>"Plan of Action to remove Immediate Jeopardy:<br>1. At least 2 staff will be on duty any time (client #8) is present in the home regardless of the number of other clients present.<br>2. All items with glass such as mirrors and picture frames will be removed from the common areas in the house until further notice.<br>3. Immediately upon (client #8) exhibiting cues of escalating anger and aggression such as yelling, cursing, stating she is upset, and making physical threats against self or others, one staff person will direct and ensure all other clients are moved to a | | | |

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| | safe area away from (client #8) and remain with them until all clam (sic.).<br>4. Immediately upon (client #8) exhibiting cues of escalating anger and aggression, cursing, stating she is upset, and making physical against self or others, second staff person will place themselves between (client #8) and other clients in the area and, then maintaining a safe distance from (client #8), began talking (sic.) calmly to her following the strategies outlined in her Behavior Support Plan.<br>5. If (client #8's) behavior becomes destructive and physically threatening to others and continues for more than 15 minutes QIDP/Qualified Intellectual Disabilities Professional/on call pager will be notified and 911 will be called. This applies to continuous aggressive behavior toward others. It does not apply to situations in which (client #8) is aggressive once but calms herself.<br>6. If (client #8's) destructive behavior is only directed toward her own property, staff should make no attempt to prevent this. Staff should ONLY intervene if her actions are causing harm to herself. If this destructive behavior continues without physical threats to herself or others for 45 minutes, staff will notify QIDP/on call pager and 911 will be called.<br><br>Further action Planned: | | | |

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| | (Client #8's) psychiatrist has been contacted in regards to the increase and severity of her behavior. An appointment was requested but the doctor chose to order a new medication to be added to her current medications. Her guardian has given approval for this and HRC (Human Rights Committee) approval is being sought.<br><br>IDT (interdisciplinary team) will meet as soon as possible to review current behaviors and revise Behavior Support Plan to address increase (client #8's) aggressive behavior.<br><br>(Group Living Division Manager) and (QIDP) will be responsible to ensure this plan is implemented and is successful in removing the risks to individuals."<br><br>Interview with staff #3 on 9/06/11 at 4:45 PM indicated QIDP/Qualified Intellectual Disabilities Professional #2 was on vacation and had not been at the facility since to offer training regarding the action plan. The interview indicated Group Living Division Manager #1 had been to the facility on 9/02/11 but staff #3 had been training staff on the action plan.<br><br>Observations were conducted at the facility on the evening of 9/06/11. At 5:14 PM on 9/06/11, client #2 was observed to | | | |

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| | touch client #8 on the left upper arm area as she returned to the kitchen area after setting a bowl of green beans on the table. Client #2 stated "leave me alone, stop arguing with me" and frowned at client #8 as she touched her. Client #8 was observed to frown and drew back her right hand making a fist toward client #2. Clients #1, #2, #3, #4, #5, #6, #7, and #8 were observed to have dinner at the facility at 5:15 PM. Staff #5 was observed to sit with clients #4 and #5. Staff did not sit at the table with clients #1, #2, #3, #6, #7 and #8. During bathing time on 9/06/11 at 6:30 PM, client #8 exhibited frustration while waiting for client #4 to be done with the bathroom. Staff #9 checked on client #4 and indicated to client #8 she would be done soon and to be patient. Staff #5 and #9 were observed to be in the facility's office area and staff #6 was in the accessible bathroom bathing client #3 at 6:40 PM. At 6:40 PM, client #8 was observed to open the bathroom door and expressed her frustration toward client #4, who was still in the bathroom.<br><br>Phone interview with staff #6 on 9/07/11 at 7:55 PM indicated client #8 had another behavioral outburst on 9/06/11 after the surveyor left the facility. The interview indicated the police had been called owing to the unmanageable behaviors exhibited by client #8. Phone | | | |

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| | interview with staff #5 on 9/07/11 at 8:06 PM indicated client #8 had become upset at 8:15 PM on 9/06/11 and had thrown a lamp and an electronic keyboard in the facility's bedroom hallway. The client had pushed an easy type chair up the hallway toward the living area. Staff #6 had taken clients #1, #2, #4, #5, and #6 into clients #3 and #7's bedroom for safety. Clients #3 and #7 "were already in bed for the night in their room so the other clients were taken there for safety." The interview indicated client #8 tried to get into the clients' bedroom but did not.<br><br>Interview with Group Living Division Manager/Administrator #1 on 9/08/11 at 11:00 AM indicated client #8 had severe behaviors on the evening of 9/06/11 and when staff #9 tried to intervene, the staff was punched in the eye. 911 was called according to the facility's Plan of Action of 9/01/11 and client #8 calmed herself.<br><br>Group Living Division Manager/Administrator #1 was notified on 9/08/11 at 4:15 PM the Immediate Jeopardy was not removed due to the ineffectualness of the 9/01/11 Plan of Action and the failure to keep clients safe from physical, verbal and emotional abuse.<br><br>Please refer to W127 for 4 of 4 sampled | | | |

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| | clients (#1, #2, #3 and #4), plus 4 additional clients (#5, #6, #7 and #8), for the facility's failure to ensure the rights of the clients to be free from physical, verbal and psychological abuse by a peer.<br><br>Please refer to W148 for 1 of 4 sampled clients (#3), and 2 additional clients (#6 and #7), for the facility's failure to have evidence the clients' guardians were notified of significant incidents occurring in the facility.<br><br>Please refer to W149 for 4 of 4 sampled clients (#1, #2, #3 and #4), plus 4 additional clients (#5, #6, #7 and #8), for the facility's failure to implement written policies and procedures which prohibited mistreatment, neglect or abuse of clients.<br><br>Please refer to W153 for 8 of 8 reportable incidents reviewed (clients #1, #2, #3, #4, #5 and #7), for the facility's failure to immediately report allegations of client to client physical, verbal and psychological abuse to other officials (Bureau of Developmental Disabilities Services/BDDS) in accordance with State law through established procedures.<br><br>Please refer to W154 for 3 of 8 reportable incidents reviewed, (clients #3 and #4), for the facility's failure to ensure all allegations were thoroughly investigated. | | | |

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| | 1.1-3-2(a) | | | |
| W0127 | The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients are not subjected to physical, verbal, sexual or psychological abuse or punishment.<br>Based on observation, record review, and interview for 4 of 4 sampled clients (#1, #2, #3 and #4), plus 4 additional clients (#5, #6, #7 and #8), the facility failed to ensure the rights of the clients to be free from physical, verbal and psychological abuse by a peer.<br><br>Findings include:<br><br>Observations were conducted at the facility on the evening of 9/01/11 from 4:40 PM until 7:00 PM. Upon entrance to the facility 4:40 PM, broken glass and broken pictures were observed to be on the floor in the front living room hallway | W0127 | A Behavioral Clinician has been obtiained ftor Clienti#8 and a Behavior Supporti Plan has been developed tio coincide witih tihe Plan oft Action tihati was modifted.Clienti #8's guardian has given verbal approval ftor botih plans. HRC approval was obtiained ftor botih plans and all stiaft have been tirained. A new psychiatiristi has been contiactied ftor Clienti#8 as well as a counselor. Appointimentis are being scheduled ftor each oft tihese Modiftcations are being made in tihe home tio provide a privatie room ftor Clienti#8. This will in tiurn provide a privatie room ftor Clienti#4 who was Clienti#8's roommatie. All clienti's bedroom doors now have door | 09/22/2011 |

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| | which led to the family room. The family room furniture was in disarray. A clear liquid was observed to be on the kitchen floor and the dining room tables were out of place. Staff #5 was observed to be seated on a couch in the family room with client #8. Client #8 was lying on the couch crying. Clients #1, #2, #3, #4, #5, #6, and #7 were observed to be grouped together in the facility's office/medication room with staff #6. Clients #1, #2, #3, #4, #5, #6, and #7 remained in the facility's office while RN #4 obtained the vacuum cleaner and started to vacuum up the broken glass outside the door to the office. Client #8 vacuumed some of the glass with assistance by staff #5 who also used a broom and dustpan. Staff #5 and client #8 dried the kitchen floor and rearranged the furniture.<br>At 5:12 PM, clients #1, #2, #3, #4, #5, #6, and #7 were observed to leave the office room. Client #6 was observed to finish cooking the evening meal of fish, macaroni and cheese, green beans, and fruit at 5:30 PM.<br>Clients #1, #2, #3, #4, #5, #6, #7, and #8 were observed to sit down to together and eat the evening meal at 5:45 PM. Staff #5 was observed to sit with clients #1 and #5 at the kitchen's bar area. Clients #2, #3, #4, #6, #7, and #8 were observed to sit at the dining table without staff sitting with them. Staff #6 was observed to be | | handles tihati lock Each clienti has been provided a key tio her door, in addition stiaft have a key tio each door.<br>Responsible ftor QA QIDP/SGL Manager | |

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standing in the dining room area but was not beside client #8. Client #8 was observed to sit with client #6 beside her on the right and client #3 around the corner of the table to client #8's left. RN #2 left the facility at 6:00 PM on 9/01/11.

Review of facility incident reports (Adverse Incident Reports/AIR and Medical Incident Reports/MIR on 9/02/11 at 7:00 AM and at 10:15 AM indicated the following:

1. An AIR by staff #5 on 9/01/11 from 4:10 PM until 5:05 PM indicated client #8 was physically aggressive (slapped client #2 in face, hit client #4); damaged property (pulled items off walls, broke two pictures, threw over two chairs and exercise bike, knocked glasses off of dining table); non-compliant (argued with staff); self abusive (picked up glass shards and held to her arm saying she would cut herself); and verbal aggressive (called staff and peers a "b...." told peers she hoped they died, yelled "I will kill everyone here, give me a knife I'll cut all of you."

2. An AIR by staff #9 on 8/27/11 from 8:15 PM until 8:40 PM indicated client #8 was physically aggressive (she punched staff in the face and spit on staff, attacked four clients hitting them in the head);

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| | damaged property (pulled items off walls breaking pictures and mirrors, threw furniture across the room); non-compliant (argued with staff); and verbally aggressive (cursing and yelling at staff and peers).<br><br>3. A MIR dated 8/27/11 at 8:15 PM by staff #10 indicated client #8 was physically aggressive toward her room-mate, client #4 who was asleep, hitting and scratching her leaving a 3 centimeter long mark to her right cheek and 3 scratches two inches long on the right side of her neck.<br><br>4. A MIR dated 8/27/11 at 8:15 PM by staff #10 indicated client #8 was physically aggressive toward client #5 while she was in bed. Client #8 went into her room and slapped her. Client #5 had red areas on her left upper arm and left cheek and a scratch on her left thumb.<br><br>5. A MIR dated 8/27/11 at 8:15 PM by staff #10 indicated client #8 had smacked client #2 and left a reddened area on the left side of her face.<br><br>6. A MIR dated 8/27/11 at 8:15 PM by staff #10 indicated client #8 was physically aggressive toward client #1 in the hallway, slapped her and knocked her eyeglasses off of her face. Client #1 had | | | |

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| | red areas on her right cheek.<br><br>7. A MIR dated 8/25/11 by staff #5 at 3:10 PM indicated client #8 had slapped herself on the right side of the face.<br><br>8. A MIR dated 8/25/11 by staff #5 at 3:10 PM indicated client #4 reported client #8 had hit her on the left upper leg, right upper arm and on her back.<br><br>9. A MIR dated 8/25/11 by staff #5 at 3:10 PM indicated client #7 had become agitated on the van when client #8 had started yelling.<br><br>10. A MIR dated 8/25/11 by staff #5 at 6:15 PM indicated client #3 reported client #8 had scratched her on the right thigh leaving two marks. The first was 3 inches long and the second was 2 inches in length.<br><br>Review of client #3's record on 9/02/11 at 10:45 AM, indicated an entry by staff #9 on 8/27/11 from 7:00 AM to 10:00 PM which indicated: "became very upset when (client #8) had behavior (sic.) crying and begging to go home. Stating (sic.) she didn't want to be here anymore." An entry on 8/27/11 10:00 PM to 8:00 AM shift staff #8 indicated client #3 was crying at bed checks "doesn't want to be here anymore, wants to go home due to (client | | | |

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| | #8's) behavior outburst." The entry by staff #8 indicated client #3 was still upset the morning of 8/28/11.<br><br>Review of client #8's record on 9/02/11 at 9:28 AM indicated a Case Analysis assessment dated 2/28/11 which included information regarding her history. The assessment indicated client #8 "expresses her frustration through behavioral outbursts, rather than being able to talk about her frustrations and implementing strategies to calm herself." The Case Analysis indicated no formal diagnoses for client #8 but indicated she "has a long history of emotional and behavioral disturbances." According to the Case Analysis, the client has exhibited "major depression, mood swings, explosive behaviors and self injurious behaviors." The Case Analysis indicated client #8 had been treated before for behavioral issues since she was "4 or 5 years old" and she has had "several inpatient hospitalizations" the most recent occurred in "approximately 2004."<br>The record review indicated client #8 had been admitted to the facility on 5/28/11.<br>A behavior support program/ISP dated 6/4/11 for client #8 indicated she was prescribed psychotropic medications for behavior: citalopram (antidepressant) 40 mg./milligrams daily, risperadone (antipsychotic) 2 mg. daily and | | | |

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| | benztropine 0.5 mg. twice daily for the side effects of the medications. The ISP indicated client #8 had the behaviors of self injurious and aggressive behaviors but the ISP had not been revised when client #8 exhibited the violent behaviors on 8/27/11.<br><br>The 9/02/11 9:28 AM record review indicated entries in client #8's record on a daily basis by direct contact staff:<br>An entry on 8/18/11 by staff #3 indicated client #8 had been "telling everyone to go home and saying mean things to everyone." The entry indicated client #8 bit herself on the arm, called her dad, then cursed him and threw her cell phone. Client #8 went into a peer's room and knocked over her nightstand.<br><br>On 8/21/11, staff #9 indicated client #8 had had "several temper tantrums throughout the day with several peers. Cursing and bossing."<br><br>On 8/25/11, staff #3 indicated client #8 was "upset as soon as she got in (sic.) van at w/s (workshop) today."<br><br>On 8/27/11, staff #9 indicated client #8 "was laying on couch watching tv (television)and began yelling and cussing. She threw furniture and pictures (sic.) breaking a mirror. 4 peers wore (sic.) | | | |

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| | struck by her and 1 staff was punched in the face and another spit on x2 (twice)."<br><br>Interview with RN #2 on 9/01/11 at 4:35 PM indicated client #8 had a tantrum and broke mirrors and threw furniture. The RN indicated client #8 broke pictures covered in glass, picked up some of the glass and threatened to cut herself. RN #2 indicated client #8 had wanted to eat but dinner was not ready. The interview stated client #8 had behaviors "with no warning." The interview indicated client #8 had hit client #2 in the left eye. The interview indicated client #8 had hit her peers (clients #4 and #5) last weekend. Interview with RN #2 on 9/01/11 at 4:55 PM indicated the psychiatrist had recommended a psychotropic medication change but it had not yet been implemented because the necessary approvals had not yet been obtained.<br><br>Client #2 stated on 9/01/11 at 4:50 PM that "(client #8) hit me in the left eye."<br><br>Client #5 stated on 9/01/11 at 4:48 PM she did "not want to get beat up again." Client #5 stated on 9/01/11 at 6:20 PM: "I don't want it to happen again, that's all. I don't want it to happen again. But, I'm afraid it is going to." Client #5 stated client #8 had "hit my arm, I was laying in bed, she scratched my left hand. She was | | | |

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mad because she could not see her dad" last Saturday (8/27/11).

All clients, (#1, #2, #3, #4, #5, #6 and #7), indicated they were afraid of client #8 when interviewed on 9/01/11 at 4:53 PM.

Client #3 indicated, on 9/01/11 at 6:25 PM, client #8 had behaviors last Saturday (8/27/11) at bedtime wherein client #8 hit client #4 and (client #8's room-mate was client #4) broke mirrors and pictures and awoke and frightened client #3's room-mate, client #7.

On 9/02/11 at 6:15 AM, staff #9 was interviewed. Staff #9 indicated clients #4 and #8 shared a bedroom the previous night and client #8 was still asleep. Staff #9 indicated she and staff #10 worked on 8/27/11 with clients #1, #2, #3, #4, #5, #6, #7, and #8. The clients had popcorn and a movie. Staff #9 indicated client #8 had spoken with her dad on the phone on Saturday afternoon (8/27/11), and appeared to be in a good mood. Clients went to bed in their rooms and staff #9 stated client #8 became violent "for no reason, no warning, nothing happened." Client #8 went into clients #5 and #1's bedroom and hit them. She broke mirrors and pictures in the bedroom hallway and went into clients #2 and #6's bedroom and hit client #2. Staff #9 indicated client #8

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| | slapped her and spit on staff #10. Client #4 (client #8's room-mate) was holding the bedroom door shut to keep client #8 out. Staff #9 indicated she and staff #10 got client #4 out of the bedroom and client #8 hit and scratched client #4. The interview indicated client #8 had become uncooperative Thursday 8/25/11 and would not get off of the facility van when it arrived at the facility after work.<br><br>On 9/02/11 at 6:39 AM client #6 (when asked about client #8's behaviors) stated, "Name calling and threats terrifies me. I don't like to be called names or threatened." Client #6 indicated client #8 would curse at her and make threats (to kill her and others/peers). Client #6 stated client #8 had a behavior in the van "last Thursday" (8/25/11) and knocked her glasses off of her face while coming back to the facility from the workshop.<br><br>Interview with Qualified Intellectual Disabilities Professional assistant/QIDPa #3 on 9/02/11 at 9:30 AM indicated she had called client #8's psychiatrist on 8/29/11 and the psychiatrist had returned her call on the evening of 8/30/11. The psychiatrist recommended a new medication for client #8, but as of 11:00 AM on 9/02/11, the new medication for client #8's behavior was not available for her in the facility. The interview indicated | | | |

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| | QIDPa #3 had been called to the facility on the evening of 8/27/11 regarding client #8's behavior and was aware of her aggressive/destructive behaviors. The interview indicated Qualified Intellectual Disabilities Professional staff #4 was notified of client #8's behaviors on 8/27/11 but she was on vacation at the time of the survey and had not made any revisions to client #8's programming.<br><br>Interview with client #6's guardian on 9/06/11 at 5:53 PM indicated she was concerned about her daughter. The interview indicated client #6 had a shunt placed in her head (over her right ear area) to drain fluids due to her hydrocephalic condition. The interview indicated the shunt had been placed at birth and again when the client was 15 years old. The shunt placement at age 15 had been an emergency situation when the apparatus had failed (was dislocated or clogged) and client #6 went into cardiac arrest. The interview indicated the client was vulnerable to injuries about her head/face. The interview stated a past history of being hit by a library book (by peer/client #7) and the physical aggression by client #8 could pose a "danger" to client #6's life.<br><br>1.1-3-2(a) | | | |

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| W0148 | The facility must notify promptly the client's parents or guardian of any significant incidents, or changes in the client's condition including, but not limited to, serious illness, accident, death, abuse, or unauthorized absence.<br>Based observation, record review and interview for 1 of 4 sampled clients (#3), and 2 additional clients (#6 and #7), the facility failed to have evidence the clients' guardians were notified of significant incidents occurring in the facility.<br><br>Findings include:<br><br>Observations were conducted at the facility on the evening of 9/01/11 from 4:40 PM until 7:00 PM. Upon entrance to the facility 4:40 PM, broken glass and broken pictures were observed to be on the floor in the front living room hallway which led to the family room. The family room furniture was in disarray. A clear liquid was observed to be on the kitchen floor and the dining room tables were out of place. Staff #5 was observed to be seated on a couch in the family room with client #8. Client #8 was lying on the couch crying. Clients #1, #2, #3, #4, #5, | W0148 | Since tihe opening oft tihis survey, all guardians have been contiactied by tihe Supervised Group Living Division Manager or tihe QIDP Assistianti and notifted oft tihe signiftcanti incidentis tihati have occurred ati tihis group home. The QIDP is no longer employed ati DSI and tihe SGL Division Manager is tihe acting QIDP ati tihis time The QIDP Assistianti has been retirained on requirementis ftor notiftcation oft guardians and where tihis is tio be notied on tihe intiernal incidenti reporti ftormSGL Division Manager will tirain tihe new QIDP once hired, on tihese requirementis Intiernal incidenti reportis are reviewed by tihe SGL division manager as well as all Stiatie reportis tio ensure proper notiftcation has been made.<br>Responsible for QA: QIDP/SGL Manager | 09/22/2011 |

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| | #6, and #7 were observed to be grouped together in the facility's office/medication room with staff #6. Clients #1, #2, #3, #4, #5, #6, and #7 remained in the facility's office while RN #4 obtained the vacuum cleaner and started to vacuum up the broken glass outside the door to the office. Client #8 vacuumed some of the glass with assistance by staff #5 who also used a broom and dustpan. Staff #5 and client #8 dried the kitchen floor and rearranged the furniture.<br><br>Review of facility incident reports (Adverse Incident Reports/AIR and Medical Incident Reports/MIR on 9/02/11 at 7:00 AM and at 10:15 AM indicated the following:<br><br>1. An AIR by staff #5 on 9/01/11 from 4:10 PM until 5:05 PM indicated client #8 was physically aggressive (slapped client #2 in face, hit client #4); damaged property (pulled items off walls, broke two pictures, threw over two chairs and exercise bike, knocked glasses off of dining table); non-compliant (argued with staff); self abusive (picked up glass shards and held to her arm saying she would cut herself); and verbally aggressive (called staff and peers a "b...." told peers she hoped they died, yelled "I will kill everyone here, give me a knife I'll cut all of you." | | | |

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| | 2. An AIR by staff #9 on 8/27/11 from 8:15 PM until 8:40 PM indicated client #8 was physically aggressive (she punched staff in the face and spit on staff, attacked four clients hitting them in the head); damaged property (pulled items off walls breaking pictures and mirrors, threw furniture across the room); non-compliant (argued with staff); and verbal aggressive (cursing and yelling at staff and peers).<br><br>3. A MIR dated 8/27/11 at 8:15 PM by staff #10 indicated client #8 was physically aggressive toward her room-mate, client #4 who was asleep, hitting and scratching her leaving a 3 centimeter long mark to her right cheek and 3 scratches two inches long on the right side of her neck.<br><br>4. A MIR dated 8/27/11 at 8:15 PM by staff #10 indicated client #8 was physically aggressive toward client #5 while she was in bed. Client #8 went into her room and slapped her. Client #5 had red areas on her left upper arm and left cheek and a scratch on her left thumb.<br><br>5. A MIR dated 8/27/11 at 8:15 PM by staff #10 indicated client #8 had smacked client #2 and left a reddened area on the left side of her face. | | | |

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| | 6. A MIR dated 8/27/11 at 8:15 PM by staff #10 indicated client #8 was physically aggressive toward client #1 in the hallway, slapped her and knocked her eyeglasses off of her face. Client #1 had red areas on her right cheek.<br><br>7. A MIR dated 8/25/11 by staff #5 at 3:10 PM indicated client #8 had slapped herself on the right side of the face.<br><br>8. A MIR dated 8/25/11 by staff #5 at 3:10 PM indicated client #4 reported client #8 had hit her on the left upper leg, right upper arm and on her back.<br><br>9. A MIR dated 8/25/11 by staff #5 at 3:10 PM indicated client #7 had become agitated on the van when client #8 had started yelling.<br><br>10. A MIR dated 8/25/11 by staff #5 at 6:15 PM indicated client #3 reported client #8 had scratched her on the right thigh leaving two marks. The first was 3 inches long and the second was 2 inches in length.<br><br>Review of client #3's record on 9/06/11 at 7:16 PM indicated no evidence her guardians had been notified of the incidents/injuries.<br><br>Review of client #6's record on 9/06/11 at | | | |

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|---|---|---|---|
| | 15G393 | A. BUILDING 00<br>B. WING | 09/08/2011 |

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| DEVELOPMENTAL SERVICES INC | 113 JENNINGS ST<br>NORTH VERNON, IN47265 |

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| | 6:45 PM indicated no evidence her guardians had been notified of the incidents/injuries.<br><br>Review of client #7's record on 9/06/11 at 7:40 PM indicated no evidence her guardians had been notified of the incidents/injuries.<br><br>Interview with staff #3 on 9/06/11 at 4:30 PM indicated she had not documented notifications to client guardians.<br><br>1.1-3-2(a) | | | |
| W0149 | The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.<br>Based on observation, record review, and interview for 4 of 4 sampled clients (#1, #2, #3 and #4), plus 4 additional clients (#5, #6, #7 and #8), the facility failed to implement written policies and procedures which prohibited mistreatment, neglect or abuse of clients.<br><br>Findings include: | W0149 | Additional staff have been added to each shift to ensure the health and safety of all residents in this home. Staff have been trained on the plan of action and behavior support plan for client #8. QIDP Assistant or SGL Division manager (acting QIDP), will do observations in the home at least weekly for one month to ensure plans are being implemented and policies and procedures are | 09/09/2011 |

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| | Observations were conducted at the facility on the evening of 9/01/11 from 4:40 PM until 7:00 PM. Upon entrance to the facility 4:40 PM, broken glass and broken pictures were observed to be on the floor in the front living room hallway which led to the family room. The family room furniture was in disarray. A clear liquid was observed to be on the kitchen floor and the dining room tables were out of place. Staff #5 was observed to be seated on a couch in the family room with client #8. Client #8 was lying on the couch crying. Clients #1, #2, #3, #4, #5, #6, and #7 were observed to be grouped together in the facility's office/medication room with staff #6. Clients #1, #2, #3, #4, #5, #6, and #7 remained in the facility's office while RN #4 obtained the vacuum cleaner and started to vacuum up the broken glass outside the door to the office. Client #8 vacuumed some of the glass with assistance by staff #5 who also used a broom and dustpan. Staff #5 and client #8 dried the kitchen floor and rearranged the furniture.<br>At 5:12 PM, clients #1, #2, #3, #4, #5, #6, and #7 were observed to leave the office room. Client #6 was observed to finish cooking the evening meal of fish, macaroni and cheese, green beans, and fruit at 5:30 PM.<br>Clients #1, #2, #3, #4, #5, #6, #7, and #8 were observed to sit down to together and | | upheld. Random observations will continue after one month. Responsible for QA: QIDP/SGL Manager | |

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| | eat the evening meal at 5:45 PM. Staff #5 was observed to sit with clients #1 and #5 at the kitchen's bar area. Clients #2, #3, #4, #6, #7, and #8 were observed to sit at the dining table without staff sitting with them. Staff #6 was observed to be standing in the dining room area but was not beside client #8. Client #8 was observed to sit with client #6 beside her on the right and client #3 around the corner of the table to client #8's left. RN #2 left the facility at 6:00 PM on 9/01/11. Observations were conducted at the facility on the evening of 9/06/11 from 3:50 PM until 7:50 PM. At 5:14 PM on 9/06/11, client #2 was observed to touch client #8 on the left upper arm area as she returned to the kitchen area after setting a bowl of green beans on the table. Client #2 stated "leave me alone, stop arguing with me" and frowned at client #8 as she touched her. Client #8 was observed to frown and drew back her right hand making a fist toward client #2. Clients #1, #2, #3, #4, #5, #6, #7, and #8 were observed to have dinner at the facility at 5:15 PM. Staff #5 was observed to sit with clients #4 and #5. Staff did not sit at the table with clients #1, #2, #3, #6, #7 and #8. During bathing time at on 9/06/11 at 6:30 PM, client #8 exhibited frustration while waiting for client #4 to be done with the bathroom. Staff #9 checked on client #4 and indicated to client #8 she | | | |

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| | would be done soon and to be patient. Staff #5 and #9 were observed to be in the facility's office area and staff #6 was in the accessible bathroom bathing client #3 at 6:40 PM. At 6:40 PM, client #8 was observed to open the bathroom door and expressed her frustration toward client #4, who was still in the bathroom.<br><br>Review of facility incident reports (Adverse Incident Reports/AIR and Medical Incident Reports/MIR on 9/02/11 at 7:00 AM and at 10:15 AM indicated the following:<br><br>1. An AIR by staff #5 on 9/01/11 from 4:10 PM until 5:05 PM indicated client #8 was physically aggressive (slapped client #2 in face, hit client #4); damaged property (pulled items off walls, broke two pictures, threw over two chairs and exercise bike, knocked glasses off of dining table); non-compliant (argued with staff); self abusive (picked up glass shards and held to her arm saying she would cut herself); and verbally aggressive (called staff and peers a "b..." told peers she hoped they died, yelled "I will kill everyone here, give me a knife I'll cut all of you."<br><br>2. An AIR by staff #9 on 8/27/11 from 8:15 PM until 8:40 PM indicated client #8 was physically aggressive (she punched | | | |

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| | staff in the face and spit on staff, attacked four clients hitting them in the head); damaged property (pulled items off walls breaking pictures and mirrors, threw furniture across the room); non-compliant (argued with staff); and verbally aggressive (cursing and yelling at staff and peers).<br><br>3. A MIR dated 8/27/11 at 8:15 PM by staff #10 indicated client #8 was physically aggressive to her room-mate, client #4 who was asleep, hitting and scratching her leaving a 3 centimeter long mark to her right cheek and 3 scratches two inches long on the right side of her neck.<br><br>4. A MIR dated 8/27/11 at 8:15 PM by staff #10 indicated client #8 was physically aggressive toward client #5 while she was in bed. Client #8 went into her room and slapped her. Client #5 had red areas on her left upper arm and left cheek and a scratch on her left thumb.<br><br>5. A MIR dated 8/27/11 at 8:15 PM by staff #10 indicated client #8 had smacked client #2 and left a reddened area on the left side of her face.<br><br>6. A MIR dated 8/27/11 at 8:15 PM by staff #10 indicated client #8 was physically aggressive toward client #1 in | | | |

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| | the hallway, slapped her and knocked her eyeglasses off of her face. Client #1 had red areas on her right cheek.<br><br>7. A MIR dated 8/25/11 by staff #5 at 3:10 PM indicated client #8 had slapped herself on the right side of the face.<br><br>8. A MIR dated 8/25/11 by staff #5 at 3:10 PM indicated client #4 reported client #8 had hit her on the left upper leg, right upper arm and on her back.<br><br>9. A MIR dated 8/25/11 by staff #5 at 3:10 PM indicated client #7 had become agitated on the van when client #8 had started yelling.<br><br>10. A MIR dated 8/25/11 by staff #5 at 6:15 PM indicated client #3 reported client #8 had scratched her on the right thigh leaving two marks. The first was 3 inches long and the second was 2 inches in length.<br><br>Review of client #3's record on 9/02/11 at 10:45 AM, indicated an entry by staff #9 on 8/27/11 from 7:00 AM to 10:00 PM which indicated: "became very upset when (client #8) had behavior (sic.) crying and begging to go home. Stating (sic.) she didn't want to be here anymore." An entry on 8/27/11 10:00 PM to 8:00 AM shift by staff #8 indicated client #3 was crying at | | | |

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| | bed checks "doesn't want to be here anymore, wants to go home due to (client #8's) behavior outburst." The entry by staff #8 indicated client #3 was still upset the morning of 8/28/11.<br><br>The 9/02/11 9:28 AM record review indicated entries in client #8's record on a daily basis by direct contact staff:<br>An entry on 8/18/11 by staff #3 indicated client #8 had been "telling everyone to go home and saying mean things to everyone." The entry indicated client #8 bit herself on the arm, called her dad, then cursed him and threw her cell phone. Client #8 went into a peer's room and knocked over her nightstand.<br>On 8/21/11, staff #9 indicated client #8 had had "several temper tantrums throughout the day with several peers. Cursing and bossing."<br>On 8/25/11, staff #3 indicated client #8 was "upset as soon as she got in (sic.) van at w/s (workshop) today."<br>On 8/27/11, staff #9 indicated client #8 "was laying on couch watching tv (television)and began yelling and cussing. She threw furniture and pictures (sic.) breaking a mirror. 4 peers wore (sic.) struck by her and 1 staff was punched in the face and another spit on x2 (twice).'<br><br>Review of agency policies and procedures on 9/06/11 at 1:30 PM indicated a | | | |

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| | Standard Operating Procedure for Identifying and Reporting Suspected Abuse and Neglect dated 4/12/2006. The review indicated the agency prohibited client abuse and neglect. Definitions were in the procedure:<br><br>"1. Physical Abuse: The intentional or willful infliction of physical injury....<br>2. Verbal/Emotional Abuse: Includes oral, written, and/or gestured language that includes disparaging or derogatory remarks. Also includes demeaning tones or harsh language. Includes unreasonable confinements, intimidation or humiliation.<br>4. Neglect: Placing an individual in a situation that may endanger his or her life or health; includes failure to provide appropriate care...or supervision."<br><br>Interview with RN #2 on 9/01/11 at 4:35 PM indicated client #8 had a tantrum, broke mirrors and threw furniture. The RN indicated client #8 broke pictures covered in glass, picked up some of the glass and threatened to cut herself. RN #2 indicated client #8 had wanted to eat but dinner was not ready. The interview stated client #8 had behaviors "with no warning." The interview indicated client #8 had hit client #2 in the left eye. The interview indicated client #8 had hit her peers (clients #4 and #5) last weekend.<br>Interview with RN #2 on 9/01/11 at 4:55 | | | |

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| | PM indicated the psychiatrist had recommended a psychotropic medication change but it had not yet been implemented because the necessary approvals had not yet been obtained.<br><br>Client #2 stated on 9/01/11 at 4:50 PM that "(client #8) hit me in the left eye."<br><br>Client #5 stated on 9/01/11 at 4:48 PM she did "not want to get beat up again." Client #5 stated on 9/01/11 at 6:20 PM: "I don't want it to happen again, that's all. I don't want it to happen again. But, I'm afraid it is going to." Client #5 stated client #8 had "hit my arm, I was laying in bed, she scratched my left hand. She was mad because she could not see her dad" last Saturday (8/27/11).<br><br>All clients, (#1, #2, #3, #4, #5, #6 and #7), indicated they were afraid of client #8 when interviewed on 9/01/11 at 4:53 PM.<br><br>Client #3 indicated, on 9/01/11 at 6:25 PM, client #8 had behaviors last Saturday (8/27/11) at bedtime wherein client #8 hit client #4 and (client #8's room-mate was client #4) broke mirrors and pictures and awoke and frightened client #3's room-mate, client #7.<br><br>On 9/02/11 at 6:15 AM, staff #9 was interviewed. Staff #9 indicated clients #4 | | | |

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| | and #8 shared a bedroom the previous night and client #8 was still asleep. Staff #9 indicated she and staff #10 worked on 8/27/11 with clients #1, #2, #3, #4, #5, #6, #7, and #8. The clients had popcorn and a movie. Staff #9 indicated client #8 had spoken with her dad on the phone on Saturday afternoon (8/27/11), and appeared to be in a good mood. Clients went to bed in their rooms and staff #9 stated client #8 became violent "for no reason, no warning, nothing happened." Client #8 went into clients #5 and #1's bedroom and hit them. She broke mirrors and pictures in the bedroom hallway and went into clients #2 and #6's bedroom and hit client #2. Staff #9 indicated client #8 slapped her and spit on staff #10. Client #4 (client #8's room-mate) was holding the bedroom door shut to keep client #8 out. Staff #9 indicated she and staff #10 got client #4 out of the bedroom and client #8 hit and scratched client #4. The interview indicated client #8 had become uncooperative Thursday 8/25/11 and would not get off of the facility van when it arrived at the facility after work.<br><br>On 9/02/11 at 6:39 AM client #6 (when asked about client #8's behaviors) stated, "Name calling and threats terrifies me. I don't like to be called names or threatened." Client #6 indicated client #8 would curse at her and make threats (to | | | |

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| | kill her and others/peers). Client #6 stated client #8 had a behavior in the van "last Thursday" (8/25/11) and knocked her glasses off of her face while coming back to the facility from the workshop.<br><br>Phone interview with staff #6 on 9/07/11 at 7:55 PM indicated client #8 had another behavioral outburst on 9/06/11 after the surveyor left the facility. The interview stated the police had been called owing to the "unmanageable" behaviors exhibited by client #8. Phone interview with staff #5 on 9/07/11 at 8:06 PM indicated client #8 had become upset at 8:15 PM on 9/06/11 and had thrown a lamp and an electronic keyboard in the facility's bedroom hallway. The client had pushed an easy type chair up the hallway toward the living area. Staff #6 had taken clients #1, #2, #4, #5, and #6 into clients #3 and #7's bedroom for safety. Clients #3 and #7 were already in bed for night in their room so the others were taken there for "safety." The interview indicated client #8 tried to get into the clients' bedroom but did not.<br><br>Interview with Group Living Division Manager/Administrator #1 on 9/08/11 at 11:00 AM indicated client #8 had severe behaviors on the evening of 9/06/11 and when staff #9 tried to intervene, the staff was punched in the eye. 911 was called | | | |

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| | according to the facility's Plan of Action of 9/01/11 and client #8 calmed herself. The interview indicated it was the agency's policy to protect clients from mistreatment, neglect and abuse (physical, verbal, psychological).<br><br>1.1-3-2(a) | | | |
| W0153 | The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.<br>Based on record review and interview for 8 of 8 reportable incidents reviewed (clients #1, #2, #3, #4, #5 and #7), the facility failed to immediately report allegations of client to client physical, verbal and psychological abuse to other officials (Bureau of Developmental Disabilities Services/BDDS) in accordance with State law through established procedures.<br><br>Findings include:<br><br>Review of facility incident reports (Adverse Incident Reports/AIR and Medical Incident Reports/MIR on 9/02/11 at 7:00 AM and at 10:15 AM indicated the following: | W0153 | The QIDP is no longer employed ati DSI. Stiaft did reporti appropriatiely per intiernal policies The QIDP Assistianti has been retirained on agency policies and procedures regarding reporting incidentis oft potiential abuse or neglecti Once a QIDP is hired tihis QIDP will be tirained on agency policies and procedures as well as Medicaid regulations. The SGL Manager or designee reviews all intiernal incidenti reportis tio ensure compliance in tihese areas All employees are required tio updatie Abuse/Neglecti and Incidenti reporting tiraining annually. Additional retiraining will be required should non-compliance be discovered.<br>Responsible ftor QA QIDP/SGL Manager | 09/22/2011 |

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| | 1. An AIR by staff #9 on 8/27/11 from 8:15 PM until 8:40 PM indicated client #8 was physically aggressive (she punched staff in the face and spit on staff, was physically aggressive to four clients (hitting them in the head); damaged property (pulled items off walls breaking pictures and mirrors, threw furniture across the room); non-compliant (argued with staff); and verbally aggressive (cursing and yelling at staff and peers).<br><br>2. A MIR dated 8/27/11 at 8:15 PM by staff #10 indicated client #8 was physically aggressive to her room-mate, client #4 who was asleep, hitting and scratching her leaving a 3 centimeter long mark to her right cheek and 3 scratches two inches long on the right side of her neck.<br><br>3. A MIR dated 8/27/11 at 8:15 PM by staff #10 indicated client #8 was physically aggressive to client #5 while she was in bed. Client #8 went into her room and slapped her. Client #5 had red areas on her left upper arm and left cheek and a scratch on her left thumb.<br><br>4. A MIR dated 8/27/11 at 8:15 PM by staff #10 indicated client #8 had smacked client #2 and left a reddened area on the left side of her face. | | | |

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| | 5. A MIR dated 8/27/11 at 8:15 PM by staff #10 indicated client #8 was physically aggressive to client #1 in the hallway slapped her and knocked her eyeglasses off of her face. Client #1 had red areas on her right cheek.<br><br>6. A MIR dated 8/25/11 by staff #5 at 3:10 PM indicated client #4 reported client #8 had hit her on the left upper leg, right upper arm and on her back.<br><br>7. A MIR dated 8/25/11 by staff #5 at 3:10 PM indicated client #7 had become agitated on the van when client #8 had started yelling.<br><br>8. A MIR dated 8/25/11 by staff #5 at 6:15 PM indicated client #3 reported client #8 had scratched her on the right thigh leaving two marks. The first was 3 inches long and the second was 2 inches in length.<br><br>Review of facility Bureau of Developmental Disabilities Services/BDDS reports on 9/06/11 at 1:00 PM indicated the incidents of 8/27/11 regarding clients #1, #2, #4, #5 and #8 had not been reported to BDDS until 9/02/11. The BDDS reports indicated Qualified Intellectual Disabilities | | | |

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| | Professional/QIDP #2 had been notified on 8/27/11 but had not notified Administrator #1 until 8/31/11.<br><br>Interview with administrator #1 on 9/02/11 at 10:30 AM indicated the incidents on 8/27/11 had not been reported to the Bureau of Developmental Disabilities Services/BDDS by Qualified Intellectual Disabilities Professional/QIDP #2.<br><br>Interview with Group Living Division Manager/Administrator #1 on 9/08/11 at 11:00 AM indicated the incidents on 8/25/11 had not been reported to BDDS.<br><br>1.1-3-1(b)(5)<br>1.1-3-2(a) | | | |
| W0154 | The facility must have evidence that all alleged violations are thoroughly investigated.<br>Based on record review and interview for 3 of 8 reportable incidents reviewed (clients #3, #4 and #7), the facility failed to ensure all allegations were thoroughly investigated.<br><br>Findings include: | W0154 | SGL Division Manger or designee will review all intiernal and BDDS incidenti reportis tio identifty tihe need ftor investigations. Incidentis requiring investigations will be tiracked tio ensure compliance witih agency policy and Medicaid regulations. SGL division manager will retirain currenti QIDP's and any QIDP hired on policy regarding investigations. | 09/22/2011 |

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| | Review of facility incident reports (Adverse Incident Reports/AIR and Medical Incident Reports/MIR on 9/02/11 at 7:00 AM and at 10:15 AM indicated the following:<br><br>1. A MIR dated 8/25/11 by staff #5 at 3:10 PM indicated client #4 reported client #8 had hit her on the left upper leg, right upper arm and on her back.<br><br>2. A MIR dated 8/25/11 by staff #5 at 3:10 PM indicated client #7 had become agitated on the van when client #8 had started yelling.<br><br>3. A MIR dated 8/25/11 by staff #5 at 6:15 PM indicated client #3 reported client #8 had scratched her on the right thigh leaving two marks. The first was 3 inches long and the second was 2 inches in length.<br><br>Review of facility Bureau of Developmental Disabilities Services/BDDS reports on 9/06/11 at 1:00 PM indicated the incidents of 8/25/11 regarding clients #3, #4 and #7 had not been investigated.<br><br>Interview with Group Living Division Manager/Administrator #1 on 9/08/11 at 11:00 AM indicated the no further investigations/reports regarding the | | Responsible ftor QA SGL Manager | |

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| | incidents on 8/25/11.<br><br>1.1-3-2(a) | | | |
| W0159 | Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional.<br>Based on observation, record review and interview for 4 of 4 sampled clients (#1, #2, #3, and #4), and 4 additional clients (#5, #6, #7, and #8), the facility failed to ensure the qualified mental retardation professional (qualified intellectual disabilities professional/QIDP) integrated, monitored and coordinated each client's active treatment program. The QIDP failed to integrate training in the clients' programs regarding self protection. The QIDP failed to monitor client #6's program plan to ensure information regarding her shunt was present. The QIDP failed to coordinate with others to ensure allegations were reported and investigated and failed to ensure physical therapy assessments and wheelchair modifications were completed.<br><br>Findings include:<br><br>Please refer to W153 for 8 of 8 reportable incidents reviewed (clients #1, #2, #3, #4, | W0159 | Each clienti's has been tirained on saftetiy response in emergency, speciftcally regarding response tio possible aggressive behaviors ftrom Clienti#8. Each clienti's programs will be updatied tio include fturtiher tiraining on selft protiection. Clienti #6's program plan/risk plan will be updatied tio include more inftormation regarding her shunti PT assessmentis ftor clienti#1 and #3 and wheelchair modiftcations ftor clienti#3 have been completied The QIDP is no longer employed ati DSI Stiaft did reporti appropriatiely per intiernal policies The QIDP Assistianti has been retirained on agency policies and procedures regarding reporting incidentis oft potiential abuse or neglecti. Once a QIDP is hired tihis QIDP will be tirained on agency policies and procedures as well as Medicaid regulations. The SGL Manager or designee reviews all intiernal incidenti reportis tio ensure compliance in tihese areas All employees are required tio updatie Abuse/Neglecti and Incidenti | 09/27/2011 |

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| | #5 and #7), for the QIDP's failure to immediately report allegations of client to client physical, verbal and psychological abuse to other officials (The Bureau of Developmental Disabilities Services/BDDS) in accordance with State law through established procedures.<br><br>Please refer to W154 for 3 of 8 reportable incidents reviewed, (clients #3 and #4), for the QIDP's failure to ensure all allegations were thoroughly investigated.<br><br>Please refer to W210 for 2 of 4 sampled clients (#1 and #3), for the QIDP's failure to ensure clients' mobility needs were assessed.<br><br>Please refer to W227 for 4 of 4 sampled clients (#1, #2, #3 and #4) and 4 additional clients (#5, #6, #7 and #8), for the QIDP's failure to ensure the clients were trained on how to protect themselves against physical aggression.<br><br>Please refer to W240 for 1 additional client, (#6), for the QIDP's failure to include special instructions regarding the possibility of trauma to the client's shunt in the client's program plan.<br><br>Please refer to W436 for 1 of 4 clients who used adaptive equipment, (client #3), for the QIDP's failure to ensure her | | reporting tiraining annually.<br>Additional retiraining will be required should non-compliance be discovered. SGL Division Manger or designee will review all intiernal and BDDS incidenti reportis tio identifty tihe need ftor investigations Incidentis requiring investigations will be tiracked tio ensure compliance witih agency policy and Medicaid regulations. SGL division manager will retirain currenti QIDP's and any QIDP hired on policy regarding investigations.<br>Responsible ftor QA QIDP/SGL Manager | |

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| | wheelchair was equipped properly.<br><br>1.1-3-3(a) | | | |
| W0210 | Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission.<br>Based on observation, record review and interview for 2 of 4 sampled clients (#1 and #3), the facility failed to ensure the clients' mobility needs were assessed.<br><br>Findings include:<br><br>During observations at the facility on 9/01/11 from 4:40 PM until 7:00 PM client #3 was observed to use a collapsible type wheelchair for mobility. Client #1 was observed to walk about the facility with an awkward gait.<br><br>During observations at the facility on the morning of 9/02/11 from 6:10 AM until 7:30 AM, client #3 was observed to utilize the collapsible wheelchair instead of her new one.<br><br>Review of client #1's record on 9/06/11 at 7:20 PM indicated her diagnoses included, but were not limited to, cerebral palsy and bilateral posterior tendon insufficiency. The record review indicated | W0210 | Clientis#1 and #3 each had a PT assessmenti on9/9/11 and any new recommendations have been initiatied as parti oft tiheir program Clienti#3 has received her new wheelchair and has had an OT assessmenti Again any new recommendations have been included in her program. Assessmentis will be updatied annually or more ftrequenti as needed due tio changing needs oft tihe clienti QIDP will review all clienti ftles tio ensure compliance<br>Responsible for QA: QIDP/SGL Manager | 09/15/2011 |

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| | the client had a physical therapy evaluation with accompanying home exercise program dated 6/2009. The review indicated the client's physical therapy status had not been reevaluated at the time of the survey.<br><br>Review of client #3's record on 9/06/11 at 7:16 PM indicated her diagnoses included but were not limited to cerebral palsy and spastic paraplegia. The review indicated the client had a physical therapy evaluation with accompanying home exercise program dated 9/2008. The review indicated the client's physical therapy status had not been reevaluated at the time of the survey.<br><br>Interview with staff #3 on 9/06/11 at 4:30 PM indicated clients #1 and #3 had not had new Physical Therapy evaluations at the time of the resurvey.<br><br>This deficiency was cited on 7/15/11. The facility failed to implement a systemic plan of correction to prevent recurrence.<br><br>1.1-3-4(a) | | | |
| W0227 | The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. | | | |

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| | Based on observation, record review and interview for 4 of 4 sampled clients (#1, #2, #3 and #4) and 4 additional clients (#5, #6, #7 and #8), the facility failed to ensure the clients were trained on how to protect themselves against physical aggression.<br><br>Findings include:<br><br>Observations were conducted at the facility on the evening of 9/06/11. At 5:14 PM on 9/06/11, client #2 was observed to touch client #8 on the left upper arm area as she returned to the kitchen area after setting a bowl of green beans on the table. Client #2 stated "leave me alone, stop arguing with me" and frowned at client #8 as she touched her. Client #8 was observed to frown and drew back her right hand making a fist toward client #2. Clients #1, #2, #3, #4, #5, #6, #7, and #8 were observed to have dinner at the facility at 5:15 PM. Staff #5 was observed to sit with clients #4 and #5. Staff did not sit at the table with clients #1, #2, #3, #6, #7 and #8. During bathing time at on 9/06/11 at 6:30 PM, client #8 exhibited frustration while waiting for client #4 to be done with the bathroom. Staff #9 checked on client #4 and indicated to client #8 she would be done soon and to be patient. Staff #5 and #9 were observed to be in the facility's office area and staff | W0227 | Each clienti has been tirained on whati tio do in tihe eventi oft aggressive behaviors in tiheir home Each clienti' s programs will be updatied tio include fturtiher tiraining on selft protiection QIDP's will be retirained on responsibilitiy tio revise clienti programs tio address speciftc needs as tihey arise QIDP's review clientis progress montihly tiowards goals Responsible ftor QA QIDP/SGL Manager | 09/27/2011 |

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| | #6 was in the accessible bathroom bathing client #3 at 6:40 PM. At 6:40 PM, client #8 was observed to open the bathroom door and expressed her frustration toward client #4, who was still in the bathroom.<br><br>Review of facility incident reports (Adverse Incident Reports/AIR and Medical Incident Reports/MIR on 9/02/11 at 7:00 AM and at 10:15 AM indicated the following:<br><br>1. An AIR by staff #5 on 9/01/11 from 4:10 PM until 5:05 PM indicated client #8 was physically aggressive (slapped client #2 in face, hit client #4); damaged property (pulled items off walls, broke two pictures, threw over two chairs and exercise bike, knocked glasses off of dining table); non-compliant (argued with staff); self abusive (picked up glass shards and held to her arm saying she would cut herself); and verbal aggressive (called staff and peers a "b...." told peers she hoped they died, yelled "I will kill everyone here, give me a knife I'll cut all of you."<br><br>2. An AIR by staff #9 on 8/27/11 from 8:15 PM until 8:40 PM indicated client #8 was physically aggressive (she punched staff in the face and spit on staff, attacked four clients hitting them in the head); damaged property (pulled items off walls | | | |

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| | breaking pictures and mirrors, threw furniture across the room); non-compliant (argued with staff); and verbally aggressive (cursing and yelling at staff and peers).<br><br>3. A MIR dated 8/27/11 at 8:15 PM by staff #10 indicated client #8 was physically aggressive toward her room-mate, client #4 who was asleep, hitting and scratching her leaving a 3 centimeter long mark to her right cheek and 3 scratches two inches long on the right side of her neck.<br><br>4. A MIR dated 8/27/11 at 8:15 PM by staff #10 indicated client #8 was physically aggressive toward client #5 while she was in bed. Client #8 went into her room and slapped her. Client #5 had red areas on her left upper arm and left cheek and a scratch on her left thumb.<br><br>5. A MIR dated 8/27/11 at 8:15 PM by staff #10 indicated client #8 had smacked client #2 and left a reddened area on the left side of her face.<br><br>6. A MIR dated 8/27/11 at 8:15 PM by staff #10 indicated client #8 was physically aggressive toward client #1 in the hallway, slapped her and knocked her eyeglasses off of her face. Client #1 had red areas on her right cheek. | | | |

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7. A MIR dated 8/25/11 by staff #5 at 3:10 PM indicated client #8 had slapped herself on the right side of the face.

8. A MIR dated 8/25/11 by staff #5 at 3:10 PM indicated client #4 reported client #8 had hit her on the left upper leg, right upper arm and on her back.

9. A MIR dated 8/25/11 by staff #5 at 3:10 PM indicated client #7 had become agitated on the van when client #8 had started yelling.

10. A MIR dated 8/25/11 by staff #5 at 6:15 PM indicated client #3 reported client #8 had scratched her on the right thigh leaving two marks. The first was 3 inches long and the second was 2 inches in length.

1. Review of client #1's record on 9/06/11 at 7:20 PM indicated no evidence her Individual Support Plan/ISP of 10/14/10 had been revised to include methodology on what to do if someone physically attacked her or if she were frightened by someone. The record review indicated no interdisciplinary (IDT) meetings regarding the incidents of 9/01/11, 8/27/11, or 8/25/11. When interviewed on 9/06/11 at 4:10 PM client #1 stated client #8 had "knocked my glasses off" of her face and

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| | she was still "scared" of client #8. Client #1 stated she did not want to be called "b...." anymore. The interview indicated no meetings regarding the behavior episodes had been held with the client.<br><br>2. Review of client #2's record on 9/06/11 at 7:32 PM indicated no evidence her Individual Support Plan/ISP of 9/22/10 had been revised to include methodology on what to do if someone physically attacked her or if she were frightened by someone. The record review indicated no interdisciplinary (IDT) meetings regarding the incidents of 9/01/11, 8/27/11, or 8/25/11.<br><br>3. Review of client #3's record on 9/06/11 at 7:16 PM indicated no evidence her Individual Support Plan/ISP of 4/11/11 had been revised to include methodology on what to do if someone physically attacked her or if she were frightened by someone. The record review indicated no interdisciplinary (IDT) meetings regarding the incidents of 9/01/11, 8/27/11, or 8/25/11. When interviewed on 9/06/11 at 4:00 PM client #3 stated she was not scared of client #8 "unless something happens." The interview indicated no meetings regarding the behavior episodes had been held with the client.<br><br>4. Review of client #4's record on 9/06/11 | | | |

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| | at 7:26 PM indicated no evidence her ISP of 11/12/10 had been revised to include methodology on what to do if someone physically attacked her or if she were frightened by someone. The record review indicated no interdisciplinary (IDT) meetings regarding the incidents of 9/01/11, 8/27/11, or 8/25/11. When interviewed on 9/06/11 at 4:05 PM client #4 stated, when asked if she was concerned or scared about anything, the client stated she was upset by "(client #8)" and pointed at her.<br><br>5. Review of client #5's record on 9/06/11 at 7:34 PM indicated no evidence her ISP of 5/24/11 had been revised to include methodology on what to do if someone physically attacked her or if she were frightened by someone. The record review indicated no interdisciplinary (IDT) meetings regarding the incidents of 9/01/11, 8/27/11, or 8/25/11.<br><br>6. Review of client #6's record on 9/06/11 at 6:45 PM indicated no evidence her ISP of 10/25/10 had been revised to include methodology on what to do if someone physically attacked her or if she were frightened by someone. The record review indicated no interdisciplinary (IDT) meetings regarding the incidents of 9/01/11, 8/27/11, or 8/25/11. When interviewed on 9/06/11 at 3:55 PM client | | | |

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| | #6 stated she "was still a little terrified of (client #8). "The interview indicated client #6 had no training in how to protect herself from aggression or what to do if frightened of someone or something. The interview indicated no meetings regarding the behavior episodes had been held with the client.<br><br>7. Review of client #7's record on 9/06/11 at 7:40 PM indicated no evidence her ISP of 10/07/10 had been revised to include methodology on what to do if someone physically attacked her or if she were frightened by someone. The record review indicated no interdisciplinary (IDT) meetings regarding the incidents of 9/01/11, 8/27/11, or 8/25/11. Confidential interview indicated client #7 was following staff around which was uncharacteristic of her. The interview indicated client #7 was manifesting fear and anxiety as a result of client #8's disruptive behaviors.<br><br>1.1-3-4(a) | | | |

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| W0240 | The individual program plan must describe relevant interventions to support the individual toward independence.<br>Based on observation, record review and interview for 1 additional client, (#6), the facility failed to include special instructions regarding the possibility of trauma to the client's shunt in the client's program plan.<br><br>Findings include:<br><br>Observations were conducted at the facility on the evening of 9/01/11 from 4:40 PM until 7:00 PM. Upon entrance to the facility 4:40 PM, broken glass and broken pictures were observed to be on the floor in the front living room hallway which led to the family room. The family room furniture was in disarray. A clear liquid was observed to be on the kitchen floor and the dining room tables were out of place. Staff #5 was observed to be seated on a couch in the family room with client #8. Client #8 was lying on the couch crying. Clients #1, #2, #3, #4, #5, #6, and #7 were observed to be grouped together in the facility's office/medication room with staff #6. Clients #1, #2, #3, #4, #5, #6, and #7 remained in the facility's office while RN #4 obtained the vacuum cleaner and started to vacuum up the broken glass outside the door to the office. Client #8 vacuumed some of the glass | W0240 | Clienti#6's program/risk plan will be revised tio include more speciftc inftormation regarding her shunti and tihe potiential problems relatied tio tirauma tio tihe shuntStiaft will be retirained on tihe revised plan QIDP will updatie plans annually or more ftrequenti as needed<br>Responsible ftor QA QIDP/SGL Manager , Agency nurse | 09/27/2011 |

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| | with assistance by staff #5 who also used a broom and dustpan. Staff #5 and client #8 dried the kitchen floor and rearranged the furniture.<br><br>Review of client #6's record on 9/06/11 at 6:45 PM indicated her diagnoses included, but were not limited to, hydrocephalous, Grande Mal seizures, Cerebral Palsy, limited peripheral and low vision. The record review indicated an Individual Support Plan/ISP dated 10/25/10 with accompanying Health Risk Plans/HRP by RN #2. A Health Risk Plan for Hydrocephalus by RN #2 indicated she had a shunt placed at birth and again in 5/98. The ISP and the HRP contained no information regarding where the shunt was placed or the risk of trauma to client #6's shunt might pose. The HRP for Grande Mal Seizures indicated the client should avoid stressful situations. The HRP for limited peripheral and low vision indicated client #6 was vulnerable to falls.<br><br>Interview with RN #2 on 9/01/11 at 4:35 PM indicated client #8 had a tantrum, broke mirrors and threw furniture. The RN indicated client #8 broke pictures covered in glass, picked up some of the glass and threatened to cut herself. RN #2 indicated client #8 had wanted to eat but dinner was not ready. The interview indicated client #8 had behaviors "with no | | | |

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| | warning." The interview indicated client #8 had hit client #2 in the left eye. The interview indicated client #8 had hit her peers (clients #4 and #5) last weekend. Interview with RN #2 on 9/01/11 at 4:55 PM indicated the psychiatrist had recommended a psychotropic medication change but it had not yet been implemented because the necessary approvals had not yet been obtained.<br><br>On 9/02/11 at 6:39 AM client #6 (when asked about client #8's behaviors) stated, "Name calling and threats terrifies me. I don't like to be called names or threatened." Client #6 indicated client #8 would curse at her and make threats (to kill her and others/peers). Client #6 stated client #8 had a behavior in the van "last Thursday" (8/25/11) and knocked her glasses off of her face while coming back to the facility from the workshop.<br><br>Interview with client #6's guardian on 9/06/11 at 5:53 PM indicated she was concerned about her daughter. The interview indicated client #6 had a shunt placed in her head (over her right ear area) to drain fluids due to her hydrocephalic condition. The interview indicated the shunt had been placed at birth and again when the client was 15 years old. The shunt placement at age 15 had been an emergency situation when the apparatus | | | |

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| | had failed (was dislocated or clogged) and client #6 went into cardiac arrest. The interview indicated the client was vulnerable to injuries about her head/face. The interview stated a past history of being hit by a library book (by peer/client #7) and the physical aggression by client #8 was a "danger" to client #6's life.<br><br>1.1-3-4(a) | | | |
| W0266 | The facility must ensure that specific client behavior and facility practices requirements are met.<br>Based on observation, record review and interview for 4 of 4 sampled clients (#1, #2, #3, and #4), and 4 additional clients (#5, #6, #7, and #8), the facility failed to meet the Condition of Participation: Behavior Management and Facility Practices.<br>The facility failed to ensure the rights of clients to be free of neglect, verbal, psychological and physical abuse by failing to implement strategies to address client #8's behaviors. The facility failed to ensure law enforcement was used in a behavior plan for client #8 in lieu of behavioral management techniques. The facility failed to include behavior medication in client #8's plan. | W0266 | A Behavioral Clinician has been obtiained ftor Client#8 and a Behavior Supporti Plan has been developed tio coincide witih tihe Plan oft Action tihati was modifted The behavior supporti plan includes inftormation on tihe use oft behavior medication ftor client#8. The plan oft action was modifted tio indicatie tihe responsibilitiy oft detiermining when tio involve law enftorcementi ftalls on tihe QIDP on call person. Clienti#8's guardian has given verbal approval ftor botih plans HRC approval was obtiained ftor botih plans and all stiaft have been tirained A new psychiatiristi has been contiactied ftor Client#8 as well as a counselor. Appointimentis are being scheduled ftor each oft tihese Modiftcations are being made in tihe home tio provide a privatie room ftor | 09/22/2011 |

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| | Findings include:<br><br>Based on observation, record review and interview for 4 of 4 sampled clients (#1, #2, #3, and #4), and 4 additional clients (#5, #6, #7, and #8), the facility failed to ensure the rights of clients to be free of neglect, verbal, psychological and physical abuse by failing to implement strategies to address client #8's behaviors. The facility failed to ensure law enforcement was used in a behavior plan for client #8 in lieu of behavioral management techniques. The facility failed to include behavior medication in client #8's plan.<br><br>Based on observation, record review and interview for 4 of 4 sampled clients (#1, #2, #3, and #4), and 4 additional clients (#5, #6, #7, and #8), the facility failed to ensure their behavior practices did not encourage the use of local law enforcement in lieu of behavior management techniques to manage client aggression and property destruction. The facility failed to ensure behavior management techniques for verbal, physical and self abuse were included in client #8's program and implemented effectively; and the facility failed to include behavioral medication in the client's program. | | Clienti#8. This will in tiurn provide a privatie room ftor Client#4 who was Clienti#8's roommatie All clienti's bedroom doors now have door handles tihati lock Each clienti has been provided a key tio her door, in addition stiaft have a key tio each door. QIDP assistianti and SGL division manager/acting QIDP or designee will conducti random observations ati leasti weekly tio ensure compliance ftor one montih Random observations will continue ati leasti montihly after one montih<br>Responsible for QA: QIDP/SGL Manager | |

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| | Please refer to W127 for 4 of 4 sampled clients (#1, #2, #3 and #4), plus 4 additional clients (#5, #6, #7 and #8), the facility failed to ensure the rights of the clients to be free from physical, verbal and psychological abuse by a peer by failing to implement behavioral programming effectively.<br><br>Please refer to W288 for 1 additional client (#8), the facility failed to ensure the use of local law enforcement was not used as a substitute for active treatment programming.<br><br>Please refer to W289 for 1 additional client (#8), the facility failed to incorporate interventions to manage client #8's inappropriate behaviors (verbal, physical, and self abuse) into her program plan.<br><br>Please refer to W312 for 1 additional client who used drugs for inappropriate behavior, (client #8), the facility failed to ensure the use of the behavior drug was included in the client's plan.<br><br>1.1-3-5(a) | | | |

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| W0288 | Techniques to manage inappropriate client behavior must never be used as a substitute for an active treatment program.<br>Based on observation, record review and interview for 1 additional client (#8), the facility failed to ensure the use of local law enforcement was not used as a substitute for active treatment programming.<br><br>Findings include:<br><br>1. Observations were conducted at the facility on the evening of 9/01/11 from 4:40 PM until 7:00 PM. Upon entrance to the facility 4:40 PM, broken glass and broken pictures were observed to be on the floor in the front living room hallway which led to the family room. The family room furniture was in disarray. A clear liquid was observed to be on the kitchen floor and the dining room tables were out of place. Staff #5 was observed to be seated on a couch in the family room with client #8. Client #8 was lying on the couch crying. Clients #1, #2, #3, #4, #5, #6, and #7 were observed to be grouped together in the facility's office/medication room with staff #6. Clients #1, #2, #3, #4, #5, #6, and #7 remained in the facility's office while RN #4 obtained the vacuum cleaner and started to vacuum up the broken glass outside the door to the office. Client #8 vacuumed some of the glass | W0288 | A Behavior Supporti Plan has been developed which includes replacementi behaviors tio work witih clienti#8 on. The plan oft action was modifted tio indicatie tihe responsibilitiy oft detiermining when tio involve law enftorcementi ftalls on tihe QIDP/on call person. Clienti#8's guardian has given verbal approval ftor botih plans HRC approval was obtiained ftor botih plans and all stiaft have been tirained QIDP assistianti and SGL division manager/acting QIDP or designee will conducti random observations ati leasti weekly tio ensure compliance ftor one montih Random observations will continue ati leasti montihly after one montih<br>Responsible ftor QA QIDP/SGL Manager | 09/22/2011 |

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| | with assistance by staff #5 who also used a broom and dustpan. Staff #5 and client #8 dried the kitchen floor and rearranged the furniture. Interview with RN #2 on 9/01/11 at 4:35 PM indicated client #8 had a tantrum, broke mirrors and threw furniture. The RN indicated client #8 broke pictures covered in glass, picked up some of the glass and threatened to cut herself. RN #2 indicated client #8 had wanted to eat but dinner was not ready. The interview stated client #8 had behaviors "with no warning." The interview indicated client #8 had hit client #2 in the left eye. The interview indicated client #8 had hit her peers (clients #4 and #5) last weekend.<br><br>2. Observations were conducted at the facility on the evening of 9/06/11. At 5:14 PM on 9/06/11, client #2 was observed to touch client #8 on the left upper arm area as she returned to the kitchen area after setting a bowl of green beans on the table. Client #2 stated "leave me alone, stop arguing with me" and frowned at client #8 as she touched her. Client #8 was observed to frown and drew back her right hand making a fist toward client #2. Clients #1, #2, #3, #4, #5, #6, #7, and #8 were observed to have dinner at the facility at 5:15 PM. Staff #5 was observed to sit with clients #4 and #5. Staff did not sit at the table with clients #1, #2, #3, #6, | | | |

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| | #7 and #8. During bathing time at on 9/06/11 at 6:30 PM, client #8 exhibited frustration while waiting for client #4 to be done with the bathroom. Staff #9 checked on client #4 and indicated to client #8 she would be done soon and to be patient. Staff #5 and #9 were observed to be in the facility's office area and staff #6 was in the accessible bathroom bathing client #3 at 6:40 PM. At 6:40 PM, client #8 was observed to open the bathroom door and expressed her frustration toward client #4, who was still in the bathroom.<br><br>Phone interview with staff #6 on 9/07/11 at 7:55 PM indicated client #8 had another behavioral outburst on 9/06/11 after the surveyor left the facility. The interview stated the police had been called owing to the "unmanageable" behaviors exhibited by client #8. Phone interview with staff #5 on 9/07/11 at 8:06 PM indicated client #8 had become upset at 8:15 PM on 9/06/11 and had thrown a lamp and an electronic keyboard in the facility's bedroom hallway. The client had pushed an easy type chair up the hallway toward the living area. Staff #6 had taken clients #1, #2, #4, #5, and #6 into clients #3 and #7's bedroom for safety. Clients #3 and #7 were already in bed for night in their room. Clients were taken into their room for "safety." The interview indicated client #8 tried to get into the clients' | | | |

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| | bedroom but did not.<br><br>Interview with Group Living Division Manager/Administrator #1 on 9/08/11 at 11:00 AM indicated client #8 had severe behaviors on the evening of 9/06/11 and when staff #9 tried to intervene, the staff was punched in the eye. 911 was called according to the facility's Plan of Action of 9/01/11 and client #8 calmed herself.<br><br>The Plan of Action for dealing with client #8's behaviors was reviewed on 9/01/2011 at 8:45 PM which included the following:<br><br>"If (client #8's) behavior becomes destructive and physically threatening to others and continues for more than 15 minutes QIDP/Qualified Intellectual Disabilities Professional/on call pager will be notified and 911 will be called. This applies to continuous aggressive behavior toward others. It does not apply to situations in which (client #8) is aggressive once but calms herself.<br>If (client #8's) destructive behavior is only directed toward her own property, staff should make no attempt to prevent this. Staff should ONLY intervene if her actions are causing harm to herself. If this destructive behavior continues without physical threats to herself or others for 45 minutes, staff will notify QIDP/on call | | | |

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| | pager and 911 will be called."<br><br>The plan called for the use of local law enforcement to intervene with client #8's behaviors rather than incorporating effective behavioral management strategies such as the agency approved Nonviolent Crisis Intervention (physical escorts/blocking techniques) methods.<br><br>1.1-3-5(a) | | | |
| W0289 | The use of systematic interventions to manage inappropriate client behavior must be incorporated into the client's individual program plan, in accordance with §483.440(c)(4) and (5) of this subpart.<br>Based on observation, record review, and interview for 1 additional client (#8), the facility failed to incorporate interventions to manage client #8's inappropriate behaviors (verbal, physical, and self abuse) into her program plan.<br><br>Findings include: | W0289 | A behavior supporti plan has been developed and approved by tihe tieam as parti oft clien#8's program plan. Clienti#8's guardian has given approval ftor tihis plan and HRC approval has been obtiained All stiaft have been tirained on tihis plan QIDP assistianti and SGL division manager/acting QIDP or designee will conducti random observations ati leasti weekly tio ensure compliance | 09/22/2011 |

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| | Observations were conducted at the facility on the evening of 9/01/11 from 4:40 PM until 7:00 PM. Upon entrance to the facility 4:40 PM, broken glass and broken pictures were observed to be on the floor in the front living room hallway which led to the family room. The family room furniture was in disarray. A clear liquid was observed to be on the kitchen floor and the dining room tables were out of place. Staff #5 was observed to be seated on a couch in the family room with client #8. Client #8 was lying on the couch crying. Clients #1, #2, #3, #4, #5, #6, and #7 were observed to be grouped together in the facility's office/medication room with staff #6. Clients #1, #2, #3, #4, #5, #6, and #7 remained in the facility's office while RN #4 obtained the vacuum cleaner and started to vacuum up the broken glass outside the door to the office. Client #8 vacuumed some of the glass with assistance by staff #5 who also used a broom and dustpan. Staff #5 and client #8 dried the kitchen floor and rearranged the furniture.<br><br>Review of facility incident reports (Adverse Incident Reports/AIR and Medical Incident Reports/MIR on 9/02/11 at 7:00 AM and at 10:15 AM indicated the following:<br><br>1. An AIR by staff #5 on 9/01/11 from | | ftor one montih Random observations will continue ati leasti montihly after one montih Responsible ftor QA QIDP/SGL Manager | |

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| | 15G393 | A. BUILDING 00<br>B. WING | 09/08/2011 |

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| | 4:10 PM until 5:05 PM indicated client #8 was physically aggressive (slapped client #2 in face, hit client #4); damaged property (pulled items off walls, broke two pictures, threw over two chairs and exercise bike, knocked glasses off of dining table); non-compliant (argued with staff); self abusive (picked up glass shards and held to her arm saying she would cut herself); and verbal aggressive (called staff and peers a "b...." told peers she hoped they died, yelled "I will kill everyone here, give me a knife I'll cut all of you."<br><br>2. An AIR by staff #9 on 8/27/11 from 8:15 PM until 8:40 PM indicated client #8 was physically aggressive (she punched staff in the face and spit on staff, attacked four clients hitting them in the head); damaged property (pulled items off walls breaking pictures and mirrors, threw furniture across the room); non-compliant (argued with staff); and verbally aggressive (cursing and yelling at staff and peers).<br><br>3. A MIR dated 8/27/11 at 8:15 PM by staff #10 indicated client #8 was physically aggressive toward her room-mate, client #4 who was asleep, hitting and scratching her leaving a 3 centimeter long mark to her right cheek and 3 scratches two inches long on the | | | |

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| | right side of her neck.<br><br>4. A MIR dated 8/27/11 at 8:15 PM by staff #10 indicated client #8 was physically aggressive toward client #5 while she was in bed. Client #8 went into her room and slapped her. Client #5 had red areas on her left upper arm and left cheek and a scratch on her left thumb.<br><br>5. A MIR dated 8/27/11 at 8:15 PM by staff #10 indicated client #8 had smacked client #2 and left a reddened area on the left side of her face.<br><br>6. A MIR dated 8/27/11 at 8:15 PM by staff #10 indicated client #8 was physically aggressive toward client #1 in the hallway, slapped her and knocked her eyeglasses off of her face. Client #1 had red areas on her right cheek.<br><br>7. A MIR dated 8/25/11 by staff #5 at 3:10 PM indicated client #8 had slapped herself on the right side of the face.<br><br>8. A MIR dated 8/25/11 by staff #5 at 3:10 PM indicated client #4 reported client #8 had hit her on the left upper leg, right upper arm and on her back.<br><br>9. A MIR dated 8/25/11 by staff #5 at 3:10 PM indicated client #7 had become agitated on the van when client #8 had | | | |

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| | started yelling.<br><br>10. A MIR dated 8/25/11 by staff #5 at 6:15 PM indicated client #3 reported client #8 had scratched her on the right thigh leaving two marks. The first was 3 inches long and the second was 2 inches in length.<br><br>Review of client #8's record on 9/02/11 at 9:28 AM indicated a Case Analysis assessment dated 2/28/11 which included information regarding her history. The assessment indicated client #8 "expresses her frustration through behavioral outbursts, rather than being able to talk about her frustrations and implementing strategies to calm herself." The Case Analysis indicated no formal diagnoses for client #8 but indicated she "has a long history of emotional and behavioral disturbances." According to the Case Analysis, the client has exhibited "major depression, mood swings, explosive behaviors and self injurious behaviors." The Case Analysis indicated client #8 had been treated for behavioral issues since she was "4 or 5 years old" and she has had "several inpatient hospitalizations" the most recent occurred in "approximately 2004."<br>The record review indicated client #8 had a behavior support program/BSP dated 6/4/11. The BSP indicated client #8 had | | | |

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| | the behaviors of self injurious and aggressive behaviors but the BSP had not been revised when client #8 exhibited the violent behaviors on 8/27/11.<br>The BSP only contained strategies for the client if she became became upset or verbally aggressive. The staff were to verbally redirect and guide her to a quiet area to calm or do activities such as coloring and try to get her to discuss her feelings. There were no methodologies for self injurious behaviors, threatening/demeaning language, property destruction or physical aggression (hitting, punching, or spitting) in the 6/4/11 BSP.<br><br>The 9/02/11 9:28 AM record review indicated entries in client #8's record on a daily basis by direct contact staff:<br>An entry on 8/18/11 by staff #3 indicated client #8 had been "telling everyone to go home and saying mean things to everyone." The entry indicated client #8 bit herself on the arm, called her dad, then cursed him and threw her cell phone. Client #8 went into a peer's room and knocked over her nightstand.<br><br>On 8/21/11, staff #9 indicated client #8 had "several temper tantrums throughout the day with several peers. Cursing and bossing." | | | |

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| | On 8/25/11, staff #3 indicated client #8 was "upset as soon as she got in (sic.) van at w/s (workshop) today."<br><br>On 8/27/11, staff #9 indicated client #8 "was laying on couch watching tv (television)and began yelling and cussing. She threw furniture and pictures (sic.) breaking a mirror. 4 peers wore (sic.) struck by her and 1 staff was punched in the face and another spit on x2 (twice)."<br><br>Interview with RN #2 on 9/01/11 at 4:35 PM indicated client #8 had a tantrum, broke mirrors and threw furniture. The RN indicated client #8 broke pictures covered in glass, picked up some of the glass and threatened to cut herself. RN #2 indicated client #8 had wanted to eat but dinner was not ready. The interview stated client #8 had behaviors "with no warning." The interview indicated client #8 had hit client #2 in the left eye. The interview indicated client #8 had hit her peers (clients #4 and #5) last weekend.<br><br>Interview with Qualified Intellectual Disabilities Professional assistant/QIDPa #3 on 9/02/11 at 9:30 AM indicated she had been called to the facility on the evening of 8/27/11 regarding client #8's and was aware of her aggressive/destructive behaviors. The interview indicated Qualified Intellectual | | | |

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| | Disabilities Professional staff #4 was notified of client #8's behaviors on 8/25/11 and 8/27/11 but she was on vacation at the time of the survey and had not made any revisions to client #8's behavior programming.<br><br>1.1-3-5(a) | | | |
| W0312 | Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed.<br>Based on record review and interview for 1 additional client who used drugs for inappropriate behavior, (#8), the facility failed to ensure the use of the behavior drug was included in the client's plan.<br><br>Findings include:<br><br>Review of client #8's record on 9/02/11 at 9:28 AM indicated an individual support program/ISP dated 6/4/11 for client #8 which indicated she was prescribed psychotropic medications for behavior: | W0312 | A behavior supporti plan has been developed and approved by tihe tieam as parti oft clien#8's program plan. The behavior supporti plan includes inftormation on tihe use oft behavior medication ftor clienti#8. Clienti#8's guardian has given approval ftor tihis plan and HRC approval has been obtiained All stiaft have been tirained on tihis plan QIDP assistianti and SGL division manager/acting QIDP or designee will conducti random observations ati leasti weekly tio ensure compliance ftor one montih Random observations will continue ati leasti | 09/22/2011 |

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| | citalopram (antidepressant) 40 mg./milligrams daily, risperadone (antipsychotic) 2 mg. daily and benztropine 0.5 mg. twice daily for the side effects of the medications. The record review indicated the psychiatrist had prescribed the atypical antipsychotic medication Saphris 5 mg. at hour of sleep which had been implemented on 9/02/11. The ISP had not been revised to include the use of the Saphris nor had withdrawal criteria for the medication been included in the ISP.<br><br>Interview with Qualified Intellectual Disabilities Professional assistant/QIDPa #3 on 9/06/11 at 4:30 PM indicated the ISP had not yet been revised since Qualified Intellectual Disabilities Professional/QIDP staff #4 was not available to revise the ISP (she was on vacation at the time of the survey) and had not made any revisions to client #8's programming.<br><br>1.1-3-5(a) | | montihly after one montih<br>Responsible ftor QA QIDP/SGL Manager | |

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| W0436 | The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.<br>Based on observation and interview for 1 of 4 clients who used adaptive equipment, (client #3), the facility failed to ensure her wheelchair was equipped properly.<br><br>Findings include:<br><br>During observations at the facility on 9/01/11 from 4:40 PM until 7:00 PM client #3 was observed to use a collapsible type wheelchair for mobility.<br><br>During observations at the facility on the morning of 9/02/11 from 6:10 AM until 7:30 AM, client #3 was observed to utilize the collapsible wheelchair instead of her new one.<br><br>During observations at the facility on 9/06/11 from 3:45 PM until 7:50 PM client #3 was observed to use a collapsible type wheelchair for mobility. | W0436 | Clienti#3's has received a new wheelchair. QIDP's will monitior each clienti's equipmenti tio ensure tihati all ift ftunctioning properly and modiftcations and repairs will be made timely.<br>Responsible for QA: QIDP/SGL Manager | 09/15/2011 |

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| | Interview with staff #4 on 9/02/11 at 9:15 AM indicated client #3 was not using her new wheelchair because it was not fitted with the correct wheels. The chair was also not fitted with the appropriate brake handles. Staff #4 indicated the client could not reach the wheels or brake handles with the chair as it was. The chair was in need of refitting so the client could mobilize herself independently.<br>Client #3 indicated on 9/06/11 at 4:30 PM her new wheelchair was in the back hallway of the facility but she was not using it yet.<br><br>This deficiency was cited on 7/15/11. The facility failed to implement a systemic plan of correction to prevent recurrence.<br><br>1.1-3-7(a) | | | |
| W0484 | The facility must equip areas with tables, chairs, eating utensils, and dishes designed to meet the developmental needs of each client.<br>Based on observation and interview for 4 of 4 sampled clients (#1, #2, #3 and #4) and 4 additional clients (#5, #6, #7 and #8), the facility failed to provide complete table service for all clients.<br><br>Findings include: | W0484 | QIDP assistianti has made sure tihati dining utiensils are available in tihe home. Stiaft have been retirained on tihe importiance oft each clienti being able tio use dining areas and service tio meeti tiheir developmential needs QIDP assistianti and SGL division manager/acting QIDP or designee will conducti random observations ati | 09/22/2011 |

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| | During observations on 9/01/11 at 5:45 PM, clients #1, #2, #3 #4, #5, #6, #7 and #8 were observed to eat the evening meal of fish sticks, macaroni and cheese, green beans and fruit. The table service did not include knives, spoons or napkins.<br><br>Clients #1, #2, #3, #4, #5, #6, #7, and #8 were observed to have dinner at the facility at 5:15 PM on 9/06/11. The meal consisted of tater tots, green beans, and fried smoked sausage. The table service did not include knives for meat cutting.<br><br>Interview with staff #6 at 5:25 PM on 9/06/11 indicated table knives should be available for use by clients, only sharp knives were used in a limited, supervised capacity.<br><br>This deficiency was cited on 7/15/11. The facility failed to implement a systemic plan of correction to prevent recurrence.<br><br>1.1-3-8(a) | | leasti weekly tio ensure compliance ftor one montih Random observations will continue ati leasti montihly after one montih Responsible ftor QA QIDP/SGL Manager | |